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Mental health and stigma: An assessment in the educational community

Abstract

According to epidemiological data (WHO, 2022), the prevalence of mental health conditions has significantly increased after the COVID-19 However, stigma remains a persistent barrier to care for many disorders. Therefore, raising public awareness is essential to reduce stigmatization. The present study aimed to investigate whether familiarity with mental illness, either through educational programs or personal interaction can reduce stigma. In order to investigate this question, a survey was conducted among members of educational community, measuring stigma toward three mental disorders: anxiety disorder, major depressive disorder and psychotic episode. Two hypotheses were tested: Hypothesis 1: stigma scores would be lower for anxiety and depressive disorders than for psychotic episodes. Hypothesis 2: Self-reported familiarity would be associated with lower stigma. The sample consisted of 101 anonymous volunteers, members of the educational community. Results confirmed both hypotheses showing significant differences based on familiarity. Individual, whose work was related to mental health, had less negative attitudes perceived people with mental illness as less dangerous and do not consider mental illness an obstacle to an interpersonal relationship. These findings align with existing literature. In conclusion, it is important for the educational community to have greater familiarity with mental illness in order to provide appropriate support to students and to promote the destigmatization of mental illness.

Keywords: Mental illness stigma, educational community, destigma-

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tization, familiarization

Introduction

Mental health, according to the World Health Organization (WHO, 2022), is not merely the absence of mental illness but a dynamic state that enables individuals to cope with life's stressors, recognize their abilities, and contribute meaningfully to their communities. It is recognized as a fundamental human right, and its promotion enhances not only individual and social development but also broader socioeconomic progress (Zayts-Spence, Kluczewska, Vrecar, Glaser, & Wykes, 2023). Despite its importance, recent epidemiological data reveal a significant global burden, with anxiety and depressive disorders showing increases of 26% and 28%, respectively, in the aftermath of the COVID-19 pandemic (WHO, 2022).

However, stigma surrounding mental disorders remains a major barrier, depriving many individuals of access to effective treatments (Zayts-Spence et al., 2023). Moreover, stigma has been associated with adverse social outcomes such as heightened loneliness and social isolation, and exacerbation of existing mental health difficulties (Prizeman et al., 2023).

The present study focuses on stigma related to three mental disorders: anxiety disorder, depressive disorder, and psychotic episode. The first two were chosen due to their high prevalence, while the latter, though less common (1% globally), continues to carry the most severe stigma (WHO, 2022).

Stigma and mental health

The stigma of mental illness is a social phenomenon shaped by stereotypes and prejudice, leading to discrimination and marginalization (Goffman, 1986; Hantzi, 2006). It affects not only individuals with a diagnosis but also extends to their families and caregivers (Zayts-Spence et al., 2023). Its consequences are multifaceted: delayed or avoided treatment (Kessler et al., 2001; Wang et al., 2006; Kordosi et al, 2015), negative self-image and reduced self-esteem (Kleim et al., 2008; Sickel et al., 2014), dif-

ficulties in interpersonal relationships (Boyd et al., 2010; Gray et al., 2010), and significant barriers to employment (Corrigan et al., 2014). Thus, stigma serves as a major barrier both to help-seeking and to the social and occupational integration of people with mental illness.

Educational community

The educational community was selected as the study population, regardless of specialty, educational level, or sector (public or private), for two main reasons. First, teachers play a critical role in early intervention by recognizing early signs of mental disorders and guiding students toward appropriate care, provided they possess adequate knowledge and training (Yamaguchi et al., 2019). Second, teachers act as transmitters of stereotypes; their attitudes and comments shape students' adoption of either positive or negative beliefs (Muntoni & Retelsdorf, 2018). As a central pillar of socialization, the school environment may either perpetuate or reduce the stigma of mental illness. Through education and professional development, teachers can challenge myths—such as the belief that individuals with mental disorders are inherently dangerous—thereby fostering destigmatization (Smith & Applegate, 2018; Corrigan et al., 2012).

Anxiety disorders

Anxiety disorders are characterized by excessive fear, anxiety, and related behavioral disturbances. Fear is an immediate emotional response to a threat, whereas anxiety involves anticipation of potential future threats. While overlapping, fear is associated with the "fight or flight" response, whereas anxiety involves preparation and preventive planning (American Psychiatric Association [APA], 2013).

These disorders often begin in childhood and can manifest in various forms, including separation anxiety disorder, selective mutism, specific phobias, social anxiety disorder, panic disorder, and generalized anxiety disorder (APA, 2013).

Generalized anxiety disorder (GAD) is marked by persistent worry and catastrophic, overgeneralized thinking patterns (Kalpako-

glou, 2013). According to DSM-5 criteria, diagnosis requires excessive anxiety and worry for at least six months, difficulty controlling worry, and the presence of multiple symptoms, such as restlessness, fatigue, difficulty concentrating, irritability, muscle tension, or sleep disturbances (APA, 2013).

Epidemiologically, in 2019, anxiety disorders affected 301 million people worldwide, but only 25% received treatment (World Health Organization [WHO], 2022). The 12-month prevalence of GAD ranges globally from 0.4% to 3.6%, with higher rates among women and individuals in developed countries (APA, 2013).

Risk factors include genetic predisposition, temperamental traits (behavioral inhibition, negative affectivity), and environmental influences, such as childhood adversity or parental overprotection (APA, 2013; Rygh & Sanderson, 2004). Comorbidity with depressive and other anxiety disorders is high (Beck & Clark, 2010; Rygh & Sanderson, 2004).

Finally, differential diagnosis is essential to rule out medical conditions, substance- induced effects, or other psychiatric disorders (APA, 2013).

Depressive disorders

Depressive disorders are among the most common mental illnesses, characterized by persistent sadness or irritable mood accompanied by cognitive and somatic changes that significantly impair functioning (APA, 2013; NICE, 2009). Major depressive disorder (MDD) represents the classical form, while other types include dysthymia, premenstrual dysphoric disorder, substance/medication-induced depressive disorder, and depressive disorder due to medical conditions (APA, 2013).

DSM-5 criteria for MDD require five or more symptoms for at least two weeks, including depressed mood, loss of interest or pleasure, changes in sleep or weight, psychomotor agitation or retardation, fatigue, feelings of worthlessness, impaired concentration, and recurrent thoughts of death or suicide (APA, 2013). Symptoms must cause significant distress or functional impairment and not be attributable to substances or medical conditions.

Epidemiologically, over 300 million people worldwide (~4.4% of the population) suffer from depression, with higher prevalence among women, increased suicide risk, and limited treatment access in low- and middle-income countries (WHO, 2023). Risk factors include genetic (first-degree relatives), environmental (childhood adversity, stressful life events), temperamental (neuroticism), and prior medical or psychiatric conditions (APA, 2013; WHO, 2023).

Depression often co-occurs with anxiety disorders, personality disorders, and substance use disorders (APA, 2013). Differential diagnosis requires ruling out manic/hypomanic episodes, substance- or medication-induced disorders, adjustment disorders, and normal grief reactions (APA, 2013).

Psychotic episode

A psychotic episode is defined by severe disruption of reality testing, preventing adaptive perception and processing of information (Kaplan & Sadock, 2007). It primarily occurs in psychotic disorders such as schizophrenia, schizophreniform disorder, brief psychotic disorder, schizoaffective disorder, substance/medication-induced psychotic disorder, psychotic disorder due to medical conditions, delusional disorder, and shared psychotic disorder (APA, 2013). Core symptoms include delusions, hallucinations, disorganized speech and thought, grossly disorganized behavior, flat or negative affect, and cognitive deficits (especially in schizophrenia).

DSM-5 criteria for schizophrenia require two or more symptoms for at least 1 month (one of the first three: delusions, hallucinations, disorganized speech), significant social/occupational dysfunction, and overall duration of at least 6 months (APA, 2013).

Epidemiology indicates ~24 million people worldwide (~1% prevalence), with 10-20 years reduced life expectancy (WHO, 2022; Greek Ministry of Health, 2023). Onset is typically earlier in men (~20 years) and later in women (~30 years).

Risk factors include genetic (family history of psychosis) and environmental factors, such as prenatal/perinatal complications, childhood maltreatment or neglect, and psychosocial stressors in adulthood (APA, 2013; Kaplan & Sadock, 2007; Papadimitriou et

al., 2013).

Comorbidity is common with anxiety disorders, depression, substance/alcohol use, panic disorder, PTSD, and OCD (Buckley et al, 2009).

Differential diagnosis requires exclusion of other medical or psychiatric conditions, including brief psychotic disorder, mood disorders, personality disorders, intellectual disability, and cultural beliefs (APA, 2013).

The current study

Familiarity with mental illness appears to reduce stigma. Individuals experiencing depressive episodes or frequently interacting with people with mental disorders tend to hold less negative attitudes (Gierg, 2018; Steiger et al., 2022). Age and type of disorder also influence attitudes; for example, younger people may be more sensitive to substance addictions, while older adults may be more empathetic toward depression (Crisp et al., 2005). This study investigates whether familiarity—through education or direct interaction with patients—can reduce stigma. Hypothesis 1: anxiety and depressive disorders will show lower stigma scores than psychotic episodes. Hypothesis 2: self-reported familiarity with mental illness will correlate with stigma scores. Results will highlight the importance of anti-stigma programs.

Methods

The present study was conducted in 2024 within the educational community using a questionnaire developed on the basis of existing literature and distributed online. Participants included teachers of all specialties and educational levels from both public and private sectors. Responses were collected through Google Forms, coded, and analyzed using the SPSS statistical package.

Sample

The study sample consisted of 102 educators from both public and private sectors, representing all educational levels and various specialties. Most participants were women (n=89), 12 were men, and 1 identified as "other," with ages ranging from 24 to 61 years

(M=42). Regarding education, 2% had secondary education, 48% held a bachelor's degree, 48% had a master's degree, and 2% had a doctoral degree. Years of professional experience ranged from 1 to 38 (M=15.4). Participants' specialties covered various fields (see Table 1).

Table 1. Demographic characteristics of participants

Demographic characteristic	N	%
Gender		
Women	89	*87.3*
Men	12	*11.8*
Other	1	*1*
Total	102	*100*
Educational Level		
Secondary Education	2	*2*
Undergraduate Degree	49	*48*
Postgraduate Degree	49	*48*
Doctorate	2	*2*
Total	102	*100*
Specialty		
Special Support Staff	2	*2*
Visual Arts Teacher	2	*2*
Physical Education Teacher	4	*4*
Primary School Teacher	51	*52*
Drama Teacher	1	*1*
Foreign Language Teacher	12	*11*
Social Worker	7	*7*
Speech Therapist	2	*2*
Music Teacher	2	*2*
Kindergarten Teacher	3	*3*
School Nurse	1	*1*
Philologist	6	*6*
Physics Teacher	2	*2*
Chemistry Teacher	2	*2*
Psychologist	5	*5*

Questionnaire

The questionnaire consisted of three parts (see Appendix). The first part collected demographic information from the participants. The second part assessed familiarity with mental illness using the

Level of Contact Report (LCR) scale, which includes 12 situations measuring contact with individuals with mental disorders. Participants rated their familiarity from 1 to 12, with 12 indicating the highest level of contact (Arvaniti & Leivaditi, 2008). The third part focused on measuring mental health stigma using the Stigma-9 Questionnaire (STIG-9) (Gierg, 2018), adapted for three mental disorders: anxiety, depression, and psychotic episode. Participants rated statements on a four-point Likert scale, such as "I believe most people take the opinion of someone treated for an anxiety disorder less seriously." The instrument demonstrated very high reliability (Cronbach's $\alpha = 0.95$), with no item below $\alpha = 0.94$. The questionnaire was administered entirely online and distributed via the internet. Participants' responses were automatically recorded and subsequently exported for statistical analysis.

Data collection and analysis

Participants' responses were automatically recorded in a Google form specifically created for this study. The collected data were initially stored in Excel and subsequently transferred to the statistical software SPSS for analysis. The statistical analysis focused on the stigma scores associated with the three mental disorders under investigation. Furthermore, correlations were examined between these stigma scores and the Level of Contact Report (LCR) familiarity scale. Although the overall LCR and stigma scores for each disorder did not reach statistical significance, certain individual items showed indications of stronger effects. Consequently, specific LCR items were compared with the corresponding questionnaire statements to further explore potential relationships between familiarity and attitudes toward mental illness.

Results

The data were analyzed using the SPSS statistical package.Mean scores for stigma were calculated for depressive disorder ($M = 20.35$, $SD = 5.56$), anxiety disorder ($M = 20.31$, $SD = 5.37$), and psychotic episode ($M = 25.32$, $SD = 4.52$). A Pearson chi-square test revealed no significant associations between stigma and gender, educational

level, or field of specialization across the three disorders.

Correlation analyses indicated significant negative relationships between work experience and stigma for depressive disorder [$r(102) = -.31$, $p < .05$] and psychotic episode [$r(102) = -.29$, $p < .05$], but not for anxiety disorder. Similarly, age was negatively correlated with stigma toward depressive disorder ($r = -.22$, $p < .05$) and psychotic episode ($r = -.20$, $p < .05$), with no significant correlation for anxiety disorder [$r(102) = -.19$, $p > .05$].

Regarding the responses to the familiarity questionnaire with mental illness, 19.6% had watched a related film, 37.3% a documentary, 21.6% worked in relevant service settings, 12.7% personally provided services, 31.4% had a family friend affected, and 37.3% had a relative with a mental illness (Table 2).

Table 2. Statements of familiarity with mental illness

Statement	Yes	%
I have never come across a person with a mental illness	1	0.9
I have occasionally come across a person with a mental illness	20	19.6
I have watched a film about mental illness	46	45.1
I have watched a documentary about mental illness	38	37.3
I have often come across a person with a mental illness	51	50.0
I have worked with someone who had a mental illness	37	36.3
My job involves providing services to people with mental illness	22	21.6
I personally provide services to people with mental illness	13	12.7
A family friend has a mental illness	32	31.4
A relative has a mental illness	38	37.3
I live with someone who has a mental illness	7	6.9
I have a serious mental illness myself	1	0.9

Based on the responses to the LCR, three participant groups were formed:

a) those who had watched films and/or documentaries related to mental illness,
b) those who work with individuals with mental illness or provide

services to them, and

c) those who have a family friend, relative, or themselves affected by mental illness.

This grouping aimed to investigate whether, beyond the level of familiarity, the mode of familiarity influences participants' responses. Statistical analysis was conducted using **independent-samples t-tests**.

First grouping analysis results

Participants who had watched films or documentaries scored slightly higher on the statement "I believe most people would not even consider an application from someone who has undergone treatment for depression" ($M = 2.67$, $SD = 1$) than those who had not ($M = 2.60$, $SD = 0.76$), with adjusted degrees of freedom [$t(98)=0.36$, $p<0.05$] due to unequal variances (Levene's $F=4.3$, $p<0.05$). Differences on other statements were not statistically significant (see Table 3).

Table 3. First grouping analysis results

	Watched Films/ Documentaries		Not Watched		
Statement	**M**	**SD**	**M**	**SD**	**Sig.**
I believe most people take the opinion of someone who has received treatment for an anxiety disorder less seriously.	2.56	0.92	2.56	0.85	0.43
I believe most people consider someone who has received treatment for an anxiety disorder as dangerous.	2.30	1.02	2.19	0.91	0.31
I believe most people hesitate to work with someone who has received treatment for an anxiety disorder.	2.40	0.87	2.34	0.92	0.10
I believe most people think negatively about someone who has received treatment for an anxiety disorder.	2.52	0.97	2.45	0.90	0.55

	Watched Films/ Documentaries		Not Watched		
I believe most people consider an anxiety disorder a sign of personal weakness.	2.82	0.91	2.58	0.90	0.32
I believe most people hesitate to trust their child to someone who has received treatment for an anxiety disorder.	3.11	0.77	3.17	0.81	0.78
I believe most people would not even consider an application from someone who has received treatment for an anxiety disorder.	2.50	0.97	2.54	0.80	0.09
I believe most people would not form a relationship with someone who has received treatment for an anxiety disorder.	2.57	1.02	2.52	0.90	0.25
I believe most people feel uncomfortable when someone who has received treatment for an anxiety disorder lives in the neighborhood.	2.13	1.00	2.08	0.94	0.80
I believe most people take the opinion of someone who has received treatment for depression less seriously.	2.63	0.88	2.33	0.88	0.79
I believe most people consider someone who has received treatment for depression as dangerous.	2.24	0.97	2.10	0.93	0.75
I believe most people hesitate to work with someone who has received treatment for depression.	2.44	0.84	2.50	0.85	0.92
I believe most people think negatively about someone who has received treatment for depression.	2.48	0.93	2.46	0.82	0.31
I believe most people consider depression a sign of personal weakness.	2.83	0.90	2.73	1.04	0.08

	Watched Films/ Documentaries		Not Watched		
I believe most people hesitate to trust their child to someone who has received treatment for depression.	3.02	0.79	3.06	0.76	1.00
I believe most people would not even consider an application from someone who has received treatment for depression.	2.67	1.00	2.60	0.76	0.04
I believe most people would not form a relationship with someone who has received treatment for depression.	2.72	0.83	2.65	0.79	0.82
	M	**SD**	**M**	**SD**	**Sig.**
I believe most people feel uncomfortable when someone who has received treatment for depression lives in the neighborhood.	2.17	1.04	1.98	0.91	0.19
I believe most people take the opinion of someone who has received treatment for a psychotic episode less seriously.	3.20	0.76	3.10	0.78	0.81
I believe most people consider someone who has received treatment for a psychotic episode as dangerous.	3.39	0.68	3.21	0.77	0.95
I believe most people hesitate to work with someone who has received treatment for a psychotic episode.	3.33	0.67	3.15	0.71	0.68
I believe most people think negatively about someone who has received treatment for a psychotic episode.	3.11	0.82	3.17	0.69	0.46
I believe most people consider a psychotic episode a sign of personal weakness.	2.80	0.94	2.73	0.96	0.34

	Watched Films/ Documentaries		Not Watched		
I believe most people hesitate to trust their child to someone who has received treatment for a psychotic episode.	3.63	0.59	3.50	0.56	0.60
I believe most people would not even consider an application from someone who has received treatment for a psychotic episode.	3.24	0.70	3.04	0.74	0.64
I believe most people would not form a relationship with someone who has received treatment for a psychotic episode.	3.26	0.76	3.21	0.65	0.21
I believe most people feel uncomfortable when someone who has received treatment for a psychotic episode lives in the neighborhood.	3.11	0.81	2.85	0.97	0.27

Second grouping analysis results

The second grouping concerned participants whose work involved providing services to people with mental illness, who overall showed significantly lower stigma scores compared to the other group. Specifically, they reported lower agreement with the statements:

- **"less seriously taken if treated for depression"** than the other participants ($M=2.54$, $SD=0.94$) [$t(53)=-1.41$, $p<0.05$]. Levene's test ($F=6.27$, $p<0.05$) indicated unequal variances, and thus degrees of freedom were adjusted from 100 to 53.
- **"hesitation to trust with a child"** ($M=2.91$, $SD=0.51$) compared to the others ($M=3.80$, $SD=0.82$) [$t(58)=-1.15$, $p<0.01$], with Levene's test ($F=6.9$, $p<0.01$) confirming unequal variances; degrees of freedom were adjusted to 58.
- **"considered dangerous after psychotic episode"** ($M=3.26$, $SD=0.54$) than the others ($M=3.30$, $SD=0.78$) [$t(51)=-3.9$, $p<0.05$];

Levene's test (F=3.9, p<0.05) indicated unequal variances, and degrees of freedom were adjusted to 51.

- **"employment discrimination after psychotic episode"** (M=3.04, SD=0.56) than the others (M=3.20, SD=0.76) [t(48)=-0.92, p<0.05], with Levene's test (F=6.21, p<0.05) showing unequal variances; degrees of freedom were adjusted to 48.
- **"reluctance to form a relationship after psychotic episode"** (M=3.04, SD=0.56) than the others (M=3.30, SD=0.74) [t(46)=-1.73, p<0.001]; Levene's test (F=12.58, p<0.001) confirmed unequal variances and degrees of freedom were adjusted to 46.
- **"discomfort with a neighbor treated for anxiety"** (M=2.05, SD=0.86) than the others (M=2.16, SD=1.04) [t(99)=-0.58, p<0.05]; Levene's test (F=4.38, p<0.05) indicated unequal variances, and degrees of freedom were adjusted to 99.

Although differences also appeared in other statements, these were not statistically significant (see Table 4).

Table 4. Second grouping analysis results

Statement	Mental Health–Related Work		Non-Mental Health Work		Sig.
	M	SD	M	SD	Sig.
I believe most people take the opinion of someone who has received treatment for an anxiety disorder less seriously.	2.30	0.82	2.63	0.89	0.70
I believe most people consider someone who has received treatment for an anxiety disorder as dangerous.	2.04	0.88	2.30	1.00	0.13
I believe most people hesitate to collaborate with someone who has received treatment for an anxiety disorder.	2.03	0.78	2.25	0.85	0.12

Statement	Mental Health–Related Work		Non-Mental Health Work		Sig.
I believe most people think negatively of someone who has received treatment for an anxiety disorder.	2.40	0.78	2.52	0.97	0.13
I believe most people consider an anxiety disorder a sign of personal weakness.	2.35	1.07	2.72	0.86	0.06
I believe most people hesitate to trust their child to someone who has received treatment for an anxiety disorder.	3.13	0.76	3.14	0.80	0.76
I believe most people would not even consider an application from someone who has received treatment for an anxiety disorder.	2.17	0.78	2.63	0.90	0.13
I believe most people would not form a relationship with someone who has received treatment for an anxiety disorder.	2.22	0.90	2.65	0.96	0.41
I believe most people feel uncomfortable when someone who has received treatment for an anxiety disorder lives in the neighborhood.	1.70	0.82	2.23	0.97	0.45
I believe most people take the opinion of someone who has received treatment for depression less seriously.	2.30	0.63	2.54	0.94	0.01
I believe most people consider someone who has received treatment for depression as dangerous.	1.96	0.88	2.24	0.96	0.27
I believe most people hesitate to collaborate with someone who has received treatment for depression.	2.40	0.78	2.50	0.86	0.48

Statement	Mental Health–Related Work		Non-Mental Health Work		Sig.
I believe most people think negatively of someone who has received treatment for depression.	2.30	0.70	2.52	0.92	0.07
I believe most people consider depression a sign of personal weakness.	2.78	0.85	2.78	1.01	0.12
I believe most people hesitate to trust their child to someone who has received treatment for depression.	2.91	0.51	3.08	0.83	0.01
I believe most people would not even consider an application from someone who has received treatment for depression.	2.26	0.69	2.75	0.93	0.90
I believe most people would not form a relationship with someone who has received treatment for depression.	2.30	0.63	2.80	0.82	0.33
I believe most people feel uncomfortable when someone who has received treatment for depression lives in the neighborhood.	1.78	0.95	2.16	0.98	0.99
I believe most people take the opinion of someone who has received treatment for a psychotic episode less seriously.	3.04	0.77	3.19	0.77	0.76
I believe most people consider someone who has received treatment for a psychotic episode as dangerous.	3.26	0.54	3.31	0.78	0.05
I believe most people hesitate to collaborate with someone who has received treatment for a psychotic episode.	3.17	0.58	3.27	0.73	0.09

Statement	Mental Health–Related Work		Non-Mental Health Work		Sig.
I believe most people think negatively of someone who has received treatment for a psychotic episode.	3.09	0.73	3.15	0.77	0.68
I believe most people consider a psychotic episode a sign of personal weakness.	2.65	0.83	2.80	0.98	0.45
I believe most people hesitate to trust their child to someone who has received treatment for a psychotic episode.	3.43	0.51	3.61	0.59	0.80
I believe most people would not even consider an application from someone who has received treatment for a psychotic episode.	3.04	0.56	3.18	0.76	0.10
I believe most people would not form a relationship with someone who has received treatment for a psychotic episode.	3.04	0.56	3.30	0.74	<0.001
I believe most people feel uncomfortable when someone who has received treatment for a psychotic episode lives in the neighborhood.	2.78	0.80	3.05	0.92	0.77

Third grouping analysis results

The third grouping examined whether participants reported having a family friend, relative, or personal experience with mental illness. Those in this group showed lower stigma on the statement "feeling uncomfortable with a neighbor treated for anxiety" ($M = 2.05$, $SD = 0.86$) compared to the other group ($M = 2.16$, $SD = 1.04$) [$t(99) = -0.58$, $p < 0.05$]. The Levene test ($F = 4.38$, $p < 0.05$) indicated inequality of variances, and therefore the degrees

of freedom were adjusted from 100 to 99. Differences in other statements were observed but did not reach statistical significance (see Table 5).

Table 5. Third grouping analysis results

Statement	Social circle with mental illness		Social circle without mental illness		Sig
	M	SD	M	SD	Sig.
I believe most people take the opinion of someone who has received treatment for an anxiety disorder less seriously.	2.39	0.87	2.69	0.88	0.63
I believe most people consider someone who has received treatment for an anxiety disorder as dangerous.	2.11	0.95	2.34	0.98	0.56
I believe most people hesitate to cooperate with someone who has received treatment for an anxiety disorder.	2.14	0.88	2.25	0.92	0.78
I believe most people think badly of someone who has received treatment for an anxiety disorder.	2.30	0.88	2.64	0.95	0.69
I believe most people consider anxiety disorder a sign of personal weakness.	2.59	0.84	2.79	0.95	0.78
I believe most people hesitate to entrust their child to someone who has received treatment for an anxiety disorder.	3.00	0.78	3.24	0.78	0.34
I believe most people would not even consider an application from someone who has received treatment for an anxiety disorder.	2.43	0.87	2.59	0.90	0.80
I believe most people would not enter a relationship with someone who has received treatment for an anxiety disorder.	2.45	0.93	2.62	0.99	0.60

Statement	Social circle with mental illness		Social circle without mental illness		Sig
I believe most people feel uncomfortable when someone who has received treatment for an anxiety disorder lives in the neighborhood.	2.05	0.86	2.16	1.04	0.03
I believe most people take the opinion of someone who has received treatment for depression less seriously.	2.32	0.88	2.62	0.88	0.88
I believe most people consider someone who has received treatment for depression as dangerous.	2.00	0.91	2.31	0.96	0.24
I believe most people hesitate to cooperate with someone who has received treatment for depression.	2.34	0.86	2.57	0.82	0.83
I believe most people think badly of someone who has received treatment for depression.	2.43	0.97	2.50	0.80	0.08
I believe most people consider depression a sign of personal weakness.	2.75	0.97	2.81	0.98	0.73
I believe most people hesitate to entrust their child to someone who has received treatment for depression.	3.02	0.76	3.05	0.78	0.83
I believe most people would not even consider an application from someone who has received treatment for depression.	2.57	0.95	2.69	0.86	0.23
I believe most people would not enter a relationship with someone who has received treatment for depression.	2.70	0.76	2.67	0.85	0.43

Statement	Social circle with mental illness		Social circle without mental illness		Sig
I believe most people feel uncomfortable when someone who has received treatment for depression lives in the neighborhood.	1.93	0.95	2.19	1.00	0.41
I believe most people take the opinion of someone who has received treatment for a psychotic episode less seriously.	3.18	0.72	3.14	0.80	0.75
I believe most people consider someone who has received treatment for depression as dangerous.	3.27	0.76	3.33	0.71	0.55
I believe most people hesitate to cooperate with someone who has received treatment for a psychotic episode.	3.23	0.71	3.26	0.69	0.46
I believe most people think badly of someone who has received treatment for a psychotic episode.	3.11	0.75	3.16	0.77	0.82
I believe most people consider a psychotic episode a sign of personal weakness.	2.70	0.98	2.81	0.93	0.58
I believe most people hesitate to entrust their child to someone who has received treatment for a psychotic episode.	3.55	0.55	3.59	0.59	0.95
I believe most people would not even consider an application from someone who has received treatment for a psychotic episode.	3.07	0.76	3.20	0.69	0.43
I believe most people would not enter a relationship with someone who has received treatment for a psychotic episode.	3.23	0.74	3.24	0.68	0.40

Statement	Social circle with mental illness		Social circle without mental illness		Sig
I believe most people feel uncomfortable when someone who has received treatment for a psychotic episode lives in the neighborhood.	2.84	0.94	3.10	0.85	0.23

Discussion

The results indicate that stigma varies depending on the disorder; depressive and anxiety disorders had lower scores (~20) compared to psychotic episodes (~25) on a scale ranging from 1–36, confirming the first hypothesis. This difference may be related to prevalence: depression is the most common mental disorder (Kessler et al., 2016; Sinyor et al., 2016; Lim et al., 2018), with an estimated 4.4% of the global population suffering from some form of depression (WHO, 2023), while anxiety disorders are also prevalent, with 301 million people experiencing some form (WHO, 2022). For this reason, these disorders may be more familiar and carry milder stigma, despite stereotypes such as that "weak people" develop depression (Yokoya et al., 2018). On the other hand, the prevalence of psychosis is approximately 1% (WHO, 2022), which is still significant. However, the stigma associated with the spectrum of disorders connected to psychotic episodes is much more intense. Even an individual who has not developed the illness but is at high risk of experiencing a psychotic episode may carry stigma (Colizzi et al., 2020).

The analysis with demographic variables showed a negative correlation between age and work experience with stigma in depression and psychosis: the greater the age and/or work experience, the lower the stigma. This finding is supported by the literature, as studies (Crisp et al., 2005; Fogel & Ford, 2005; Mackenzie et al., 2019) have shown that stigma toward populations suffering from a mental disorder is higher among younger individuals compared to older individuals.

The second hypothesis concerned the relationship between

familiarity with mental illness and stigma. Initially, the overall FAS scores did not show any correlation. For this reason, further subgroup analyses were conducted:

The first subgrouping was based on whether participants reported having seen films and/or documentaries about mental illness. In general, lower stigma scores were observed, except for the statement "most people would not even consider an application from someone who has undergone treatment for depression," where stigma was higher. The existing literature highlights that individuals with depression may experience discrimination in the workplace (Fox et al., 2016). The increase in stigma in this statement may emphasize this prejudice in professional environments, where individuals with some form of depression are perceived as less productive (Fox et al., 2016; McGonagle & Hamblin, 2014), and this image may have been conveyed through exposure to films and/or documentaries.

The second subgrouping was based on whether participants reported that they employ or provide services to people with mental illness. In all statements, scores were lower across all three disorders. In fact, lower scores were found in statements that heavily carry the stigma of mental illness, such as "I believe that most people consider someone who has undergone treatment for depression as dangerous" and "I believe that most people would not enter into a relationship with someone who has undergone treatment for a psychotic episode." The existing literature supports that mental health professionals hold less negative attitudes than non-mental health professionals (Calicchia, 1981; Carrara et al., 2019; Henderson et al., 2014). Moreover, this more favorable stance among mental health professionals appears across different cultural contexts, such as London, Sweden, and Japan (Henderson et al., 2014). Therefore, members of the educational community who participated in the present study confirm the literature, showing that those with professional experience working with individuals with mental illness scored lower in stigma toward mental disorders. After all, mental illness stigma is a social and cultural phenomenon, and direct

experience with individuals suffering from mental illness may reduce prior beliefs and foster more positive views and attitudes toward them.

The third subgrouping was based on whether participants reported having a family friend and/or relative, or personally having a mental illness. In this subgrouping, it was initially expected that stigma would be milder and that scores would be lower. In reality, however, the only statement that had statistically significantly lower scores for the group with greater familiarity was "I believe that most people feel uncomfortable when someone who has undergone treatment for an anxiety disorder lives in the neighborhood." The reason why significantly lower stigma scores were expected was due to greater personal familiarity. The developers of the questionnaire (Gierk et al., 2018) had emphasized that when the questionnaire was completed by individuals experiencing a relapse at the time—for example, a depressive episode—they perceived the attitudes of their environment as more negative. The literature has highlighted that, apart from public stigma, there is also self-stigma experienced by the individual, which plays an important role in many aspects of life, from whether one seeks help (Sirey et al., 2001; Watson et al., 2006), to how they respond to treatment (Sirey et al., 2001; Watson et al., 2006), and how it influences later professional status and interpersonal relationships. Regarding individuals who reported having a family member or relative with mental illness, it is worth noting that the literature emphasizes that stigma is not only carried by the individual with the illness but also by their close social environment (Zayts-Spence et al., 2023).

From the interpretation of the results, it becomes evident that the stigma of mental illness can be moderated and negative attitudes reduced under specific conditions. These conditions, as shown by the analysis, are age, work experience, and close professional relationships with individuals who suffer from a mental illness. The common denominator is familiarity with mental illness, both over time and through relevant engagement. However, personal involvement may have the opposite effects. There

is evidence that even mental health professionals, while having less negative attitudes toward patients, would not choose to form close personal relationships with individuals who have a mental illness, knowing the challenges this entails (Chikaodiri et al., 2010; Steiger et al., 2022).

Further research

The present study only partially addresses the phenomenon of mental illness stigma in Greece. Future research should examine how individuals with mental illness experience stigma in the workplace and interpersonal relationships (Corrigan et al., 2014; Brohan et al., 2010). It is also important to investigate the extent to which stigma acts as a barrier or facilitator in seeking help (Clement et al., 2015). Equally significant is the exploration of how significant others, such as family and friends, experience stigma and the extent to which their personal beliefs influence the attitudes and decisions of the individual affected (Zayts-Spence et al., 2023; Phelan et al., 1998).

Limitations

A main limitation concerns the sample, which was drawn from the educational community with greater representation from primary and less from secondary education, thus restricting the generalizability of the findings (Etikan et al., 2016). Moreover, the study was conducted under conditions of anonymity, which prevented repeated measurements that could have captured potential changes in attitudes over time. Future studies could examine whether and how personal experiences, such as developing a mental illness or working in a mental health context, contribute to changes in stigma-related attitudes (Henderson et al., 2014; Corrigan & Shapiro, 2010).

Conclusion

This study highlights that stigma toward mental illness can be reduced through professional familiarity and prolonged exposure, which promote more positive attitudes (Calicchia, 1981).

Stigma impacts both affected individuals and their social environment, influencing self-confidence, self-efficacy, and interpersonal, academic, and professional outcomes (Steiger et al., 2022; Watson et al., 2007). Enhancing mental health literacy and direct engagement in educational and professional contexts improves recognition of mental health needs and supports timely intervention (Rossetto et al., 2016; Yamaguchi et al., 2019). Effective stigma reduction also requires systemic measures, including equal opportunities, medical support, interdisciplinary collaboration, and public awareness initiatives (Chikaodiri, 2010; Kordosi et al., 2015; Patel, 2004; Steiger et al., 2022; Yamaguchi et al., 2019; Zayts-Spence et al., 2023). Combining education, engagement, and structural reforms fosters inclusive, supportive, and understanding environments for individuals affected by mental illness.

These findings highlight the importance of anti-stigma interventions in educational in educational setting and suggest that familiarity-through education, professional exposure and personal contact- can significantly reduce negative attitudes towards mental illness.

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